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ISDI OUTCOME INDICATORS
A SELF-ASSESSMENT TOOL

OVERVIEW

The process of growth and quality improvement is dynamic and on going, requiring an assessment of the current situation, identification of areas where improvement can be made, design of an intervention, implementation of the intervention, and assessment of the effectiveness of the action. ISDI networks have developed to the point where it is necessary to demonstrate effectiveness and allow for comparisons both within individual networks, and among networks. The purpose of this document is to provide background information on evaluation/self-assessment, describe why assessment is important, and provide a draft tool designed to assist networks in developing a self-assessment that will enable them to provide both descriptive and quantifiable information to their members, to outside funding sources, to other agencies involved in health care, and most importantly, to enable networks to continue to grow and increase in effectiveness and efficiency.

WHY A MEASUREMENT TOOL?

The short answer to that question is, because we all want to know how we are doing, where we have areas in need of improvement, and because of our competitive natures, we want to know how we compare to others. With the current emphasis on cost containment and performance measures, it is essential that networks focus on mechanisms that can demonstrate that centralized functions performed through networks can serve to increase access to care, enhance efficiency, and result in higher quality, performance, and value to health center members and to the patients they serve.

The purpose of the Network Outcome Indicators Tool is to address the need for networks to be able to assess on-going network activities. As networks continue to develop, they must demonstrate that by joining together, they can achieve greater outcomes and benefits for the members than the health centers could accomplish on their own. Developed by the ISDI workgroup, the Network Outcome Indicators Tool is a descriptive document designed to aid networks in developing a mechanism that will assess their progress in integrating functions. Each network is likely to utilize this document differently, depending on the network's individual needs and goals. Thus, the Tool is intended to be a dynamic draft document that will change as the environment changes and as networks continue to develop and evolve.

HOW SHOULD OUR NETWORK USE THIS TOOL?

As outlined in the Collaboration and Integration Matrix (available at: http://www.bphc.hrsa.gov/chc/isdi/refdocs/isdimatrix.doc), networks can be at various stages of collaborating, sharing, and integrating within functional areas. The Network Outcome Indicators Tool offers a **sample of indicators** for each of these functional areas and stages of integration.

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The Bureau recommends the use of the Outcome Indicators Tool as a:
- **Discussion outline** for staff, Board, and collaborators to talk about the effectiveness of network activities;
- **Framework** for assessing progress in achieving network goals throughout the project period;
- **Data collection guide** for documenting the impact of network activities on operations, collaborators, populations, etc.;
- **Measurement tool** to identify superior performance in providing access to appropriate services and improving delivery of a continuum of care through an integrated, primary care, community-based health care system.

It is recommended that each network carefully review this document and begin to utilize elements of it as a self-assessment tool. The Appendix contains background information on evaluation including steps that networks may follow in deciding which outcomes to measure, and how to begin. **After you have studied the informational material, it is recommended that each network identify a minimum of two outputs and corresponding outcomes to be tracked and measured for EACH of the Core Areas (Administration, Clinical, Financial, Information Systems) that the network is sharing or integrating.** The overall goals is that ultimately a network should be able to report on at least three outcome indicators within each of the following program expectation domains: Increased Access (Expanding Health Centers), Enhanced Efficiency (Strengthening Health Centers), Higher Performance and Value (Quality Improvement in Health Centers).

Exhibit 1 provides a list of sample outcome measures that networks may examine. For example, if your network is working on the sharing or integration of corporate compliance in the administrative area, you may wish to use the outcome measures in the sample, or come up with others that more accurately reflect your work. If you are focusing on clinical integration and working on clinical guidelines and disease management, you may wish to use some of the outcome measures included in that category. The outcome measures chosen should correspond to the core areas you are working in. The next section of this document will provide you with the information that will enable you to begin this important process.

CORE AREAS OF FOCUS

Networks are given great flexibility in determining their activities. Each network is unique, depending on its state environment, collaborators, needs, and interests. The following are the four main core areas of integration:

- **Administration:** Integrating administrative functions is expected to increase economies of scale and demonstrate cost efficiencies. Several networks have established joint purchasing efforts, saving money that can be directed to patient care.

- **Clinical:** Clinical integration can result in improved consistency and quality of care. Networks have developed standardized quality improvement programs, established specialty referral groups, and standardized disease management protocols.

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- **Financial:** Financial integration can achieve increased efficiency and effectiveness. Networks are working on activities such as centralized billing functions and common financial statements.

- **Information Systems (IS):** Information systems are important for providing access to and managing clinical and financial data. By sharing the costs of information systems and the specialized staff necessary to effectively operate them, Networks have improved the quality of data and the overall cost of collecting it.

EXPECTATIONS

Networks are expected to achieve the following:
1. Increased access,
2. Enhanced efficiency,
3. Higher performance and value.

Outcome indicators should be used to demonstrate that the functions carried out by networks achieve these expectations and goals. For the purposes of this document, there are three categories of outcome indicators based on these key expectations and goals.

Access Outcome Indicator:
− Improved access to continuum of care
− Increased number of patients
− Increased units of services
− Increased types of services

Efficiency Outcome Indicator:
− Economies of scale/ reduced costs overall
− Practice management efficiencies
− Decreased cost per unit of service
− Decreased patient cycle time throughout the network

Performance and Value Outcome Indicator:
− Increased quality of care
− Improved quality of data
− Increased revenue
− Higher patient satisfaction
− Sharing of expertise and staff among collaborators
− Greater consistency in service delivery

BPHC expects networks to evaluate their progress, and recommends using this guide or another credible program evaluation tool. The process of evaluation in this document is a basic model to assist networks with the general process of self-assessment.

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PROGRAM OUTCOME MODEL FOR NETWORKS

The outcome indicators tool is based on the program outcome model for networks that depicts the relationship between inputs, functions, outputs, outcomes, and outcome indicators within the entire network. By using outcome indicators to evaluate these relationships, a network is able to demonstrate the impact of network activities [See Figure 1. below].

INPUTS   FUNCTIONS

OUTCOME INDICATORS
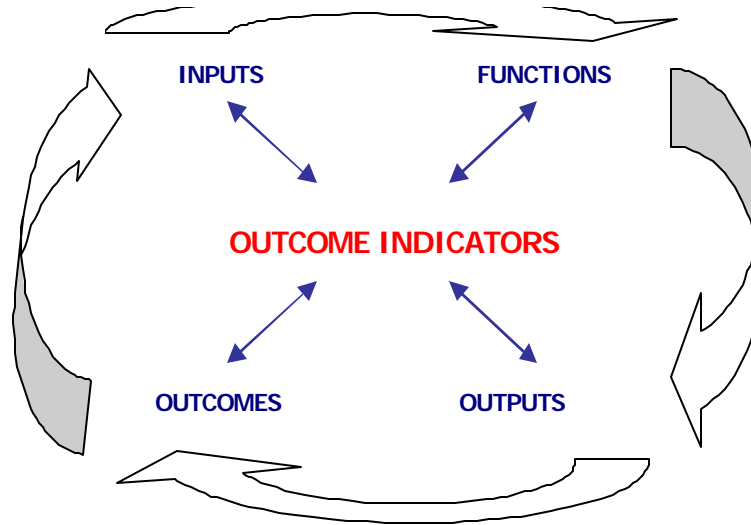
OUTCOMES   OUTPUTS

DEFINITIONS

Many community health centers and networks regularly monitor, document, and report their program inputs, functions, and outputs; however, they do not consistently track outcome indicators to understand how well they are achieving program outcomes. For the purposes of the outcome indicators tool, the following definitions are used.

- **Inputs** include resources dedicated to or consumed by the program. Examples are money, staff and staff time, volunteers and volunteer time, facilities, equipment, and supplies.
- **Functions** (activities/processes) are what the program does with the inputs to fulfill its mission. Functions include the strategies, techniques, and types of treatment that comprise the program's service methodology. For details on functions see the ISDI Collaboration and Integration Matrix.
- **Outputs** are the quantifiable direct products of program activities. They usually are measured in terms of the volume of work accomplished. For example, the numbers of encounters generated or users served.
- **Outcomes** describe the benefits or changes for individuals, populations, or health centers as a result of the network activities (and its output). The may relate to behavior, skills, knowledge, attitudes, values, condition, or other attributes. For example, an outcome would be a 20 percent increase in the number of low-income children immunized following a network-wide public awareness program on immunization.

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- **Outcome indicators** are specific items of data that are tracked to measure how well a network is achieving an outcome over a defined period of time. To define an indicator, a network should specify the following elements:

$$\text{Outcome indicator} \ = \ \frac{\text{Event}}{\text{Population}} \quad X \quad \text{Time Period(s)}$$

1. The population of interest [denominator]
2. The health (service) event [numerator]
3. The time period(s) that applies to the population and health (service) event.

Example:

CORE AREA: Clinical
NETWORK FUNCTION: Clinical Guidelines and Disease Management
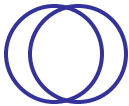**LEVEL OF INTEGRATION:** Integrated
MEASURE OF: Performance
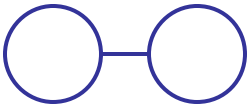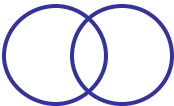
$$\text{Number of clinical guidelines standardized within 5 months} \ = \ \frac{\text{Standardization of Clinical Guidelines}}{\text{All clinical guidelines}} \quad X \ \text{5 months}$$

Event	*Standardization of clinical guidelines*
Population	*All clinical guidelines (i.e. disease management, utilization review, etc.).*
Time Period	*5 months to standardize clinical guidelines*
Outcome indicator	*Number of clinical guidelines standardized within 5 months* *May have a target goal for outcome (i.e. 70% of clinical guidelines standardized within 5 months)*

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LEVELS OF INTEGRATION WITHIN NETWORK FUNCTIONS

Products resulting from network functions are grouped by level of integration as defined below.

COLLABORATIVE	SHARED	INTEGRATED
To work together, especially in a joint intellectual effort	A part or a portion belonging to, distributed to, contributed by, or owned by a person or group	To partake of, use, experience with others; to have in common

Full integration does not necessarily mean that an integrated network is "better" than a collaborative or shared network. For example, full integration of a network where the CHCs are geographically separated may not be efficient for centralized health educators and other staff. For more information on the Process of Evaluation, please refer to the Appendix.

FUNDING AND THE TOOL

How does this tool affect my funding?
The BPHC *does not* expect networks to apply this tool (Exhibit 1) in its entirety nor will funding decisions be affected by the utilization of the tool. BPHC expects continued effort toward measuring network activities based on increased access, increased efficiency, and/or increased performance/value. It is anticipated that information gained from the use of outcome indicators and reported in semi-annual progress reports will be compiled and shared with all networks. Because uniformity is necessary to make comparisons, it anticipated that in the future, some common outcomes indicators will be requested of all networks to show progress across the Network program as a whole.

Is "Exhibit 1" a comprehensive set of outcome indicators?
No. The Network Outcome Indicators Tool is *not* a complete set of measures. This document represents only a **sample** of activities and indicators, and is expected to be used solely as a guide.

The individual health centers already have outcome indicators; can we use their outcome indicators for our network?
No. Each *network* should assess their respective activities, environments, and infrastructure to determine the most appropriate mix of outcome indicators. Although health centers and other collaborators may already have outcome indicators for their individual entities, this document is designed to help *networks* develop indicators that track data for the **entire network**, rather than one individual collaborator.

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Exhibit 1

SAMPLE
Network Outcome Indicators

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The **samples** of outcomes indicators are organized according to five ISDI core areas**.**

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PROGRAM OUTCOME MODEL FOR NETWORKS
Core Area: ADMINISTRATION

OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Human Resources (HR)	
Collaborative ▪ Joint position descriptions and advertising	**EFFICIENCY:** ▪ Number/percent of joint position descriptions ▪ Number of joint advertisements ▪ Number /percent of staff turnover ▪ Amount of time saved by using joint P.D.s **PERFORMANCE/VALUE:** ▪ Amount of savings from joint advertising

Shared
 ▪ Common HR policies and procedures
   – Standardized HR materials
   – Standardized HR policy manual
 ▪ Joint purchase of fringe benefit either "benefits" or benefit package
	EFFICIENCY:
	 ▪ Number/percent of collaborators with common HR policies
	 ▪ Number/percent of collaborators with common evaluation/performance policies for positions
	 PERFORMANCE/VALUE:
	 ▪ Amount of savings from joint purchases of fringe benefits
	 ▪ Greater number of benefits due to higher volume of employees
	 ▪ Amount of savings from shared legal costs

Integrated ▪ Centralized HR staff – Central HR department ▪ Centralized management of common fringe benefits ▪ Succession plan	**EFFICIENCY:** ▪ Number/percent of CHC staff hired centrally ▪ Number/percent of staff recruited/retained ▪ Number of successful lawsuits defended ▪ Amount of time saved at center level on recruitment **PERFORMANCE/VALUE:** ▪ Amount of savings due to centralized management ▪ Number of fringe benefits ▪ Number of candidates for job positions
Purchasing	
Collaborative ▪ Standard inventory ▪ Joint request for proposal (RFP)	**EFFICIENCY:** ▪ Number of joint RFPs ▪ Number of RFPs developed on behalf of all collaborators **PERFORMANCE/VALUE:** ▪ Amount of better pricing based on volume

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OUTPUTS Direct Products of Network Functions		EXAMPLES OF OUTCOME INDICATORS
Shared	• Joint purchasing • Enhanced terms • Enhanced quality of products	**EFFICIENCY:** • Number of joint purchases made **PERFORMANCE/VALUE:** • Amount of savings due to joint purchasing
Integrated	• Centralized purchasing department	**EFFICIENCY:** • Volume of inventory • Number/percent of items purchased centrally • Number/percent of collaborators making joint purchases **PERFORMANCE/VALUE:** • Amount of savings due to joint purchasing • Amount of staff savings

Corporate Compliance

Collaborative	• Sharing of individual self-evaluation compliance assessments • Self-assessments	**PERFORMANCE/VALUE:** • Greater interest in improvement due to self-assessments
Shared	• Standardized self-evaluation tool to monitor compliance • Some shared staff • Common policies and procedures	**ACCESS:** • Number of new recruited providers and contracted specialists
Integrated	• Centralized compliance unit/internal auditor • Corporate compliance plan • Central helpline for audit staff	**EFFICIENCY:** • Number of compliance issues addressed more rapidly • Number of staff hours trained • Amount of staff time saved at center level **PERFORMANCE:** • Amount of savings due to joint insurance policies

Medicare and Medicaid Compliance

Collaborative	• Common policies	**PERFORMANCE/VALUE:** • Greater influence with Medicaid agency and MCOs.
Shared	• Shared staff, some same but separate systems	**EFFICIENCY:** • Number/percent of shared staff • Reduced error rate on billings
Integrated	• Internal audit function • Centralized internal auditor	**EFFICIENCY:** • Number/percent of billing procedures done correctly • Number/percent of claims pended **PERFORMANCE/VALUE:** • Amount of savings due to joint audits • Amount of savings from enhanced accuracy and timeliness of billing

Program and Services Development

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OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Collaborative ▪ Shared planning efforts for programs and services ▪ Planning effort	**PERFORMANCE/VALUE:** ▪ Number of additional staff used in planning process ▪ Complimentary plans and services ▪ Number of programs & services accessed/developed
Shared ▪ Shared programs and services ▪ New programs and services developed	**ACCESS:** ▪ Number/percent of new services and programs ▪ Number/percent of patients with access to new services and programs **EFFICIENCY:** ▪ Number/percent of shared and non-duplicative programs and services **PERFORMANCE/VALUE:** ▪ Number/percent of new services and programs
Integrated ▪ Centralized program development unit ▪ New programs and services developed	**ACCESS:** ▪ Number/percent of new services and programs ▪ Number/percent of patients with access to new services and programs **EFFICIENCY:** ▪ Number/percent of specialized staff with expertise in program department **PERFORMANCE/VALUE:** ▪ Number/percent of new services and programs
Business Plan	
Collaborative ▪ Statement of intent to participate	**PERFORMANCE/VALUE:** ▪ Improved plans through sharing best practices
Shared ▪ Memorandum of Agreement ▪ Shared board training	**EFFICIENCY:** ▪ Frequency of board training(s) **PERFORMANCE/VALUE:** ▪ Number/percent /frequency of collaborator participation
Integrated ▪ Formation of a separate corporate entity and/or centralized management ▪ Continuous strategic planning activities	**EFFICIENCY:** ▪ Number of staff dedicated to the network **PERFORMANCE/VALUE:** ▪ Amount of additional expertise ▪ Number/percent/frequency of collaborator participation ▪ Number of strategic planning activities
Resource Development	

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	OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Collaborative	▪ Joint proposal or fund raising effort ▪ Written grants and proposals	**ACCESS:** ▪ Number/percent of new services and programs ▪ Number/percent of patients with access to new services and programs ▪ Number of new access points **EFFICIENCY:** ▪ Number of joint proposals written **PERFORMANCE/VALUE:** ▪ Amount of increased funding due to resource development
Shared	▪ Network proposal	**ACCESS:** ▪ Number/percent of new services and programs ▪ Number/percent of patients with access to new services and programs ▪ Number of new access points **EFFICIENCY:** ▪ Number of joint proposals written/funded **PERFORMANCE/VALUE:** ▪ Amount of increased funding due to resource development ▪ Level of diversified funding sources
Integrated	▪ Centralized resource development unit	**ACCESS:** ▪ Number/percent of new services and programs ▪ Number/percent of patients with access to new services and programs ▪ Number of new access points **EFFICIENCY:** ▪ Number of joint proposals written **PERFORMANCE** ▪ Amount of increased funding due to resource development
**Education and Public Relations: Community, Patient, Staff, Board**	

Collaborative	▪ Sharing of current educational activities
	▪ Joint activities
	▪ Joint events and materials
	  – Fact sheets
	  – Media products
		ACCESS:
		▪ Number of participants in joint activities
		▪ Number/percent of shared communication materials
		EFFICIENCY:
		▪ Number of joint activities
		PERFORMANCE/VALUE:
		▪ Amount of increased level of expertise
		▪ Amount of savings from shared materials

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OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Shared - Using standardized materials - Shared community outreach staff - Shared patient health educators - Shared trainings - Shared curriculum development - Shared education materials - Shared staff or contracts – Shared communication staff – Joint ongoing projects	**ACCESS:** - Number/percent of new education programs - Number/percent of patients with access to education services **EFFICIENCY:** - Number/percent of shared education materials, staff positions, etc. - Number/percent of shared communication materials - Number of shared staff **PERFORMANCE/VALUE:** - Amount of savings from using common materials and trainings - Number/percent of new education functions - Amount of savings from shared materials - Amount of savings from shared staff
Integrated - Centralized education functions - Centralized community promotion and outreach function - Video conferencing - Centralized communication functions – Communication department – Media campaign – Advocacy campaign	**ACCESS:** - Number/percent of new education programs - Number/percent of patients with access to education services - Number of favorable policies that increase access due to advocacy efforts **EFFICIENCY:** - Number/percent of collaborators using a standardized education program - Number of shared communication materials - Number of shared staff - Number/percent of collaborators using shared materials **PERFORMANCE/VALUE:** - Amount of savings from using common materials and trainings - Number and percent of new education functions - Number of new patients - Number of retained patients
Advocacy	
Collaborative - Joint events and materials – Fact sheets – Media products	**EFFICIENCY:** - Number/percent of shared advocacy materials **PERFORMANCE/VALUE:** - Amount of savings from shared advocacy materials

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	OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Shared	▪ Joint advocacy projects	**EFFICIENCY:** ▪ Number/percent of shared advocacy materials ▪ Number of shared staff PERFORMANCE/VALUE: ▪ Amount of savings from shared advocacy materials ▪ Amount of savings from shared staff
Integrated	▪ Centralized advocacy campaign	**ACCESS:** ▪ Number of favorable legislation and policies that increase access due to advocacy efforts **EFFICIENCY:** ▪ Number/percent of shared advocacy materials ▪ Number of shared staff ▪ Number/percent of collaborators using shared advocacy materials **PERFORMANCE/VALUE:** ▪ Amount of savings from shared advocacy materials ▪ Amount of savings from shared staff

Marketing

	OUTPUTS	EXAMPLES OF OUTCOME INDICATORS
Collaborative	▪ Joint marketing assessment ▪ Self-assessments	**PERFORMANCE/VALUE:** ▪ Reduced competition among network members
Shared	▪ Standardized materials and joint events	**ACCESS:** ▪ Number/percent of new patients brought in by marketing efforts ▪ Number of culturally/linguistically produced materials **EFFICIENCY:** ▪ Number/percent of shared marketing materials ▪ Amount of savings from shared marketing materials **PERFORMANCE/VALUE:** ▪ Number of PR venue events
Integrated	▪ Centralized and standardized marketing approach ▪ Standardized marketing plan/campaign	ACCESS: ▪ Number/percent of new patients brought in by marketing efforts EFFICIENCY: ▪ Number/percent of shared marketing materials ▪ Number/percent of collaborators using shared materials ▪ Number/percent of patient retention

Strategic Planning

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	OUTPUTS **Direct Products of Network Functions**	**EXAMPLES OF OUTCOME INDICATORS**
Collaborative	▪ Review of collaborator strategic plans – Strategic planning process ▪ Agreement on a strategic planning process	**ACCESS:** ▪ Greater understanding of collaborators' businesses **EFFICIENCY:** ▪ Number of new opportunities realized from joint planning ▪ Number of network-wide strategic planning processes
Shared	▪ Development and endorsement of network strategic plan ▪ Interactive session with board and management ▪ Internal assessment – External assessment ▪ Written plan	**ACCESS:** ▪ Number of new access points due to joint planning **PERFORMANCE/VALUE:** ▪ Number/percent of members who participate in strategic planning sessions ▪ Overall strengthening of plans through sharing of areas of success
Integrated	▪ Implementation and monitoring of network strategic plan ▪ Strategies and activities	**ACCESS:** ▪ Number of expansions and new access points due to joint planning ▪ Number of new services generated **PERFORMANCE/VALUE:** ▪ Number/percent of strategic planning goals achieved
Quality Improvement—Administrative		

Collaborative	▪ Joint education and training of staff
	▪ Joint educational materials
	  – Joint trainings
	  – Sharing of expertise
		EFFICIENCY:
		▪ Number of joint educational materials
		▪ Number of joint trainings
		PERFORMANCE/VALUE:
		▪ Number/percent of meetings with clinicians to facilitate expertise sharing

Shared	▪ Joint projects, e.g., surveys – Joint guidelines ▪ Development of quality guidelines ▪ Joint scorecards	**EFFICIENCY:** ▪ Number of joint projects **PERFORMANCE/VALUE:** ▪ Number and percent of centers using joint guidelines ▪ Number/percent employees satisfied
Integrated	▪ Standardized CQI plans and implementation at network level ▪ Standardized plan ▪ Centralized staff resources ▪ Network accreditation	**EFFICIENCY:** ▪ Number/percent of collaborators using a standardized plan **PERFORMANCE/VALUE:** ▪ Number/percent of centers using a standardized plan ▪ Number/percent of collaborators accredited
Customer Service Training		
Collaborative	▪ Best practices ▪ Best practice models	**PERFORMANCE/VALUE:** ▪ Number/percent of patients satisfied with service ▪ Number of complaints filed

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OUTPUTS Direct Products of Network Functions		EXAMPLES OF OUTCOME INDICATORS
Shared	▪ Joint training	**EFFICIENCY:** ▪ Number/percent of staff participating in joint trainings ▪ Number/percent patients retained ▪ Number/percent of dropped patients ▪ Number/percent of newly acquired patients **PERFORMANCE/VALUE:** ▪ Number/percent of patients satisfied with service ▪ Number of complaints filed
Integrated	▪ Centralized staff ▪ Customer service strategy and corrective plan ▪ Customer service standards ▪ Network analysis of patients dropped, retained, acquired	**EFFICIENCY:** ▪ Number of joint customer service policies and procedures ▪ Number/percent of collaborators using joint policies ▪ Number/percent patients retained ▪ Number/percent of dropped patients ▪ Number/percent of newly acquired patients **PERFORMANCE/VALUE:** ▪ Number/percent of patients satisfied with service ▪ Number of complaints filed ▪
Credentialing		
Collaborative	▪ Common policies and procedures	**EFFICIENCY:** ▪ Number of common credentialing policies and procedures
Shared	▪ Common policies and procedures	**EFFICIENCY:** ▪ Number of common credentialing policies and procedures
Integrated	▪ Centralized or standardized credentialing	**EFFICIENCY:** ▪ Number of providers credentialed centrally **PERFORMANCE/VALUE:** ▪ Amount of savings due to standardized credentialing both direct cost and staff time at the center level
Member Services – Managed Care		
Collaborative	▪ Common policies and procedures	**EFFICIENCY:** ▪ Number of common member services policies and procedures

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	OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Shared	▪ Joint enrollment materials ▪ Common intake and referral ▪ Establish dedicated member services unit ▪ Install online system with access to membership, provider, and claims database ▪ Develop reporting system to identify trends in service issues and develop solutions ▪ Develop mechanisms to ensure that members services staff receive timely information about benefit modifications, procedural changes, etc.	**EFFICIENCY:** ▪ Number of joint enrollment materials ▪ Number of common policy and procedures for intake and referrals **PERFORMANCE/VALUE:** ▪ Amount of savings due to joint enrollment materials ▪ Number of problems reported and resolved
Integrated	▪ Centralized or standardized member services	**EFFICIENCY:** ▪ Number of shared staff ▪ Number/percent of collaborators using standardized member services **PERFORMANCE/VALUE:** ▪ Amount of savings due to standardized member services ▪ Number of problems reported and resolved
Enrollment		
Collaborative	▪ Common policies and procedures for enrollment application process ▪ Establish enrollment verification procedure (PCP selection) ▪ Establish member notification process ▪ Establish enrollment data entry process ▪ Establish process for welcome calls within 5-8 days of enrollment	**EFFICIENCY:** ▪ Number of common policies and procedures for enrollment application process ▪ Number of member of notifications sent ▪ Number of welcome calls conducted within 5-8 days of enrollment **PERFORMANCE/VALUE:** ▪ Increased patient satisfaction reflected in patient satisfaction survey
Shared	▪ Common policies and procedures for new enrollment (individual and employer group/association members – data receipt verification, retroactive processing, rate cell assignments) ▪ Establish procedures for timely transmission of enrollment to Medicaid, MCO or employer	**EFFICIENCY:** ▪ Number of common policies and procedures for new enrollments ▪ Number of common procedures for transmission of enrollment to Medicaid, MCO or employer
Integrated	▪ Centralized policies and procedures for enrollment application process ▪ Centralized processing for new enrollment ▪ Centralized member notification process	**PERFORMANCE/VALUE:** ▪ Amount saved from centralized policies and procedures for enrollment application process ▪ Amount saved from centralized processing of new enrollment ▪ Increase patient satisfaction on timely member notification process

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OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Contracting	
Collaborative ▪ Assessment of collaborators' managed care activities ▪ Inventory of collaborator participation agreements within the marketplace ▪ Review all contracts for compliance with State and Federal regulations and for legal sufficiency	**PERFORMANCE/VALUE:** ▪ Number of collaborator participation agreements within the marketplace ▪ Number of contracts reviewed for State and Federal regulations and legal sufficiency
Shared ▪ Standard utilization review and risk management program ▪ UR program ▪ Establish basic contract parameters for use in negotiations	**PERFORMANCE/VALUE:** ▪ Number/percent of collaborators utilizing standard UR program
Integrated ▪ Contracting authority and monitoring performed at the network level ▪ Risk agreement carve outs ▪ HMO license ▪ Establish a contract monitoring tool to track performance	**PERFORMANCE/VALUE:** ▪ Number of new managed care contracts ▪ Number of improved managed care contracts
Grievances and Appeals	
Collaborative ▪ Assessment of barrier-free procedures ▪ Sharing of "Untoward Event" reports	**EFFICIENCY:** ▪ Number of barrier-free procedures **PERFORMANCE/VALUE:** ▪ Enhanced "Untoward Event" reporting
Shared ▪ Common policies and procedures for a barrier-free filing of grievance s and complaints by members ▪ Standardized "Untoward Event" report	**PERFORMANCE/VALUE:** ▪ Increased patient satisfaction in filing of grievances and complaints ▪ Consistent and enhanced method in completing "Untoward Event" reports
Integrated ▪ Centralized point of entry for all grievances and appeals ▪ Establish barrier-free procedures to facilitate the ability of all members to file grievances and complaints ▪ Centralized "Untoward Event" process and management	**PERFORMANCE/VALUE:** ▪ Quarterly reports outlining frequency, type and disposition of grievances ▪ Increase patient satisfaction in filing of grievances and complaints ▪ Amount saved from centralized grievances and complaint filing ▪ Number of resolved/unresolved "Untoward Events"
QUALITY ASSURANCE	
Collaborative ▪ Establish committee for the Network	**EFFICIENCY:** ▪ Number of committee meetings
Shared ▪ Established, written quality assurance (QA) plan (QA methodology stressing health outcomes, peer review, systematic data collection, etc.)	**EFFICIENCY:** ▪ Number of policies established for quality assurance measures
Integrated ▪ Standardized QA plan and activities network-wide ▪ Dedicated QA staff network-wide	**PERFORMANCE/VALUE:** ▪ Amount saved from network-wide QA activities

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PROGRAM OUTCOME MODEL FOR NETWORKS
Core Area: CLINICAL

OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Services and Programs	
Collaborative • Joint planning at the collaborator level • Services available to collaborators and clients • Joint planning of program and services	**ACCESS:** • Number/percent of patients with access to current services and programs • Number/percent of new services and programs • Number/percent of patients with access to services and programs at each collaborator • Number of new patients **EFFICIENCY:** • Number of shared staff **PERFORMANCE/VALUE:** • Number/percent of new services and programs
Shared • Joint planning at network level, e.g., collaborators develop coordinated programs which still involve participation on individual level • Some common internal and external referral guidelines • Staff delivering services at more than one of the participating agencies • Common guidelines • Joint programs and services	**ACCESS:** • Number/percent of new services and programs • Number/percent of patients with access to new services and programs • Number/percent of patients that remain within the network **EFFICIENCY:** • Number of common services and programs • Number/percent of collaborators using common services and programs • Number of shared staff **PERFORMANCE/VALUE:** • Number/percent of new services and program. • Number of duplicate clinical programs eliminated or modified

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OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Integrated • Joint funding, coordinated services and programs • Centers of excellence • Centralized internal and external referral and consultation program • Collapsing existing services into one • Services and programs delivered by network level staff • Programs offered at the network are not duplicated at the center level • Centralized or standardized services and programs	**ACCESS:** • Number/percent of new services and programs • Number/percent of patients with access to new services and programs **EFFICIENCY:** • Number of network-wide services and programs • Number/percent of collaborators using network-wide services and programs **PERFORMANCE/VALUE:** • Number/percent of new services and programs • Number of duplicate clinical programs eliminated and number of integrated programs initiated
Health Education	
Collaborative • Sharing educational materials and activities • Collaborators actively informed about health education programs and activities • Health education information available to clients and practitioners across the network • Joint activities	**ACCESS:** • Number of participants in joint activities • Percentage of patient panel receiving education services **EFFICIENCY:** • Number of joint activities
Shared • Some shared staff • Using common materials • Collaborators plan some activities in which several collaborators participate – staff and resources are still individual center based, e.g., health fairs, prenatal education classes, educational brochures • Shared patient health educators • Shared trainings • Shared curriculum development • Shared education materials	**ACCESS:** • Number/percent of new education programs • Number/percent of patients with access to education services • Percentage of patient panel receiving education services **EFFICIENCY:** • Number and percent of shared education materials, staff positions, etc. **PERFORMANCE/VALUE:** • Amount of savings from using common materials and trainings • Number/percent of new education functions

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	OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Integrated	▪ Centralized clinical health education function or educator ▪ Centralized on-line information resources ▪ Centralized promotion and outreach function ▪ Health education activities delivered by network staff not duplicated at the individual center level ▪ Planning performed at the network level ▪ Centralized community promotion and outreach function	**ACCESS:** ▪ Number/percent of new education programs ▪ Number/percent of patients with access to education services ▪ Percentage of patient panel receiving education services **EFFICIENCY:** ▪ Number/percent of collaborators using a standardized education program **PERFORMANCE/VALUE:** ▪ Amount of savings from using common materials and trainings ▪ Number/percent of new education functions ▪ Number/percent of patients in compliance with treatment

Clinical Guidelines and Disease Management

Collaborative	▪ Joint clinical staff meetings by discipline ▪ Common health maintenance, health education, and disease management guidelines ▪ Common health maintenance, health education, and disease management guidelines	**ACCESS:** ▪ Number of patients enrolled in structured educational programs **EFFICIENCY:** ▪ Percent of collaborators using disease management peer educators **PERFORMANCE/VALUE:** ▪ Number of new health maintenance, health education, and disease management guidelines ▪ Number of patients whose disease is being controlled/managed
Shared	▪ Shared staff educational materials ▪ Common clinical staff development programs ▪ Some shared staff ▪ Centers discuss and identify some common outcomes measures ▪ Shared staff ▪ Shared trainings ▪ Shared clinical guidelines development ▪ Shared education materials	**ACCESS:** ▪ Number of patients receiving standard, quality care from guidelines ▪ Number of patients enrolled in structured educational programs ▪ Number/percent of patients with access to interagency referrals **EFFICIENCY:** ▪ Number of shared staff positions ▪ Number of shared education materials **PERFORMANCE/VALUE:** ▪ Number of new health maintenance, health education, and disease management guidelines ▪ Amount of savings from shared staff ▪ Amount of savings from shared clinical guidelines development ▪ Number of patients whose disease is controlled/managed ▪ Number of collaborators working in the Clinical Collaboratives

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	OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Integrated	• Standardized guidelines, including disease management, utilization review, case management and triage • Outcome measures adopted and monitored at the network level • Centralized disease management function • Standard messages and programs • Integrated information systems • Participation in the Clinical Collaboratives as a network	**ACCESS:** • Number of patients enrolled in structured educational programs • Number/percent of patients with access to interagency referrals **EFFICIENCY:** • Number of standardized clinical protocols and guidelines • Number of shared staff • Number of standardized education materials • Reduced patient visit times • Number/percent of collaborators using standardized guidelines **PERFORMANCE/VALUE:** • Number of new health maintenance, health education, and disease management guidelines • Number of patients whose disease is controlled/managed
Staffing		
Collaborative	• Collaborators share strategies for recruitment • Sharing information around retention and benefits packages • Collaborators assist each other in times of provider shortages (locum tenens) • Clinical directors meet informally on a regular basis	**ACCESS:** • Number of additional specialists and other providers recruited or contracted • Number of providers in a locum tenens pool **PERFORMANCE/VALUE:** • Number of clinician meetings for sharing information
Shared	• Joint health professions training program or sponsor joint CME activities • Shared vacation coverage • Common policies for credentialing, clinical privileges and re-credentialing • Clinical directors meet formally on regular basis • Joint trainings • Shared vacation coverage	**ACCESS:** • Number of additional specialists and other providers recruited or contracted **EFFICIENCY:** • Number of joint trainings • Number of shared staff **PERFORMANCE/VALUE:** • Amount of savings from shared staff • Number/percent of providers board certified • Number/percent of staff satisfaction

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	OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Integrated	▪ Network level (single) Chief Medical Officer ▪ Shared hospitalist ▪ Common retention and benefits package ▪ Network level credentialing and re-credentialing function ▪ Network level clinical staff (may be clinical administrative) performing functions not duplicated at the individual center level ▪ Network credentialing function	**ACCESS:** ▪ Number of additional specialists and other providers recruited or contracted **EFFICIENCY:** ▪ Number of shared staff **PERFORMANCE/VALUE:** ▪ Number joint or centralized functions ▪ Amount of savings from shared staff ▪ Amount of savings from having network-wide benefits ▪ Number/percent of board certified providers ▪ Number/percent of staff satisfaction
Documentation: Medical Records, Common Forms, Policies		
Collaborative	▪ Collaborators assist each other in developing medical records forms/policies	**PERFORMANCE/VALUE** ▪ Completion of a plan for improvement of medical records
Shared	▪ Adoption (sharing) of common forms ▪ Some joint policies and procedures ▪ Network sponsored education for staff on medical records related issues (e.g., billing and coding, filing systems, confidentiality) ▪ Shared information on common forms ▪ Sharing of common policies ▪ Common forms ▪ Joint policies and procedures	**EFFICIENCY:** ▪ Number of common forms ▪ Number of joint trainings for staff on medical records **PERFORMANCE/VALUE:** ▪ Number of joint trainings for staff on medical records ▪ Percent of complete and accurate medical records
Integrated	▪ Common medical records format – electronic or paper ▪ Network level health information staff ▪ Network level functions such as policy and procedure development, chart review, billing and coding assistance, processing of record requests ▪ Standardized basic forms ▪ Uniform policies and procedures ▪ Documentation/common format ▪ EMR – centralized or standardized	**EFFICIENCY:** ▪ Number of standardized forms ▪ Number of standardized policies and procedures ▪ Number/percent of collaborators using integrated documentation tools **PERFORMANCE/VALUE:** ▪ Number/percent of collaborators using EMR ▪ Amount of provider staff time spent on medical records ▪ Medical error rate as determined by network-wide record review

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OUTPUTS Direct Products of Network Functions		EXAMPLES OF OUTCOME INDICATORS
Ancillary Services: Laboratory, Pharmacy, Radiology, Other		
Collaborative	• Joint solicitation of ancillary services contracts • Clinical directors share information about services, contractors and utilization • Clinicians aware of services available at other centers and how to refer clients • Joint contracts • Referral systems	**ACCESS:** • Number/percent of new services • Number/percent of patients with access to new services **EFFICIENCY:** • Number of joint contracts for ancillary services **PERFORMANCE/VALUE:** • Number/percent of new services
Shared	• Common vendors • Some shared staff • Joint solicitation of ancillary services contracts maintained at center level • Formal or at least streamlined mechanisms to refer clients for services from one collaborator to the other • Clinical directors plan ancillary services delivery based upon knowledge of and taking advantage of among the collaborators • Shared staff • Joint ancillary services • Number/percent of new services • Number/percent of patients with access to new services	**ACCESS:** • Number of common services **EFFICIENCY:** • Number/percent of new services • Time required for patient referrals to network members
Integrated	• Single outsource contracts or bring expertise in-house • Centralized staff • Network level services not duplicated at the individual center level • Clients access services at any of the participating centers without need for registration • Network contracts for ancillary services • Network "in-house" referral manual	**ACCESS:** • Number/percent of new services • Number/percent of patients with access to new services **EFFICIENCY:** • Number of network-wide services • Number/percent of collaborators using network-wide services **PERFORMANCE/VALUE:** • Number/percent of new services
CQI/Clinical Systems Improvement		
Collaborative	• Joint quality committee • Joint staff training • Collaborators adopt common approach to CQI • Collaborators formally discuss development of indicators and share these with each other • Joint quality committee • Joint staff training • Common CQI approach	**PERFORMANCE/VALUE:** • Number/percent of collaborators involved in CQI

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OUTPUTS Direct Products of Network Functions		EXAMPLES OF OUTCOME INDICATORS
Shared	▪ Development of common materials, indicators, and reporting formats ▪ Shared staff for CQI ▪ Joint education and preparation for individual accreditation ▪ Peer review – common format for peer review, clinicians may conduct reviews across collaborators ▪ Shared comparative data (collective) ▪ Common quality indicators ▪ Shared staff ▪ Common materials and indicators	**EFFICIENCY:** ▪ Number/percent of centers involved in joint preparation for JCAHO accreditation ▪ Number of common indicators **PERFORMANCE/VALUE:** ▪ Number/percent of centers or providers involved in peer review
Integrated	▪ Centralized support for implementation and monitoring of common quality indicators, e.g., appointment availability and wait times ▪ Centralized staff support for education, consultation and coaching of improvement efforts, data analysis and reporting ▪ Network level goals and thresholds ▪ Joint accreditation ▪ Standardized QI plans ▪ Centralized QI positions	**EFFICIENCY:** ▪ Number and percent of shared QI positions ▪ Number of joint trainings ▪ Number/percent of collaborators using standard quality indicators **PERFORMANCE/VALUE:** ▪ Number/percent of QI plans implemented ▪ Number/percent of JCAHO accredited collaborators ▪ Number/percent of centers or providers involved in peer review
Provider Management		
Collaborative	▪ Develop provider newsletter to update providers on benefit changes, procedural changes, etc. ▪ Establish peer review committee to oversee quality of care issues, review credentialing, advise on new payment systems, etc.	**ACCESS:** ▪ Number of providers contributing to newsletter **EFFICIENCY:** ▪ Number of peer review committee meetings
Shared	▪ Establish credentialing function ▪ Establish provider network of primary care physicians, specialists, hospitals, SNFs, ancillary services, etc. ▪ Develop provider manual (services covered under capitation and FFS, guidelines for pre-authorization, etc.)	**ACCESS:** ▪ Number of providers in the network of primary care physicians, specialist, hospitals, SNFs, ancillary services, etc. **EFFICIENCY:** ▪ Number of providers credentialed/re-credentialed ▪ Provider manual completed/updated
Integrated	▪ Load provider information and contract payment terms (capitation, FFS, pools) into data base ▪ Establish timely process for adding new providers/ contract terms to provider data base ▪ Develop online, demand system for generating provider directories ▪ Single peer review committee for the entire network to review issues of quality of care, credentialing, advise on new payment systems, etc.	**EFFICIENCY:** ▪ Number of peer review committee meetings **PERFORMANCE/VALUE:** ▪ Amount saved with centralized database for providers ▪ Amount saved with centralized database for contract payment
Research		

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	OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Collaborative	▪ Common data collection ▪ Collaborators discuss possible research activities and share information about individual projects ▪ Data collection	**EFFICIENCY:** ▪ Amount of common data collected
Shared	▪ Joint research projects ▪ Collaborators participate individually in common research projects ▪ Research projects	**EFFICIENCY:** ▪ Number of joint research projects **PERFORMANCE/VALUE:** ▪ Number of joint research projects
Integrated	▪ Joint internal review board ▪ Network develops and carries out research projects ▪ **Network level research department or staff** ▪ Review board ▪ Research projects	**EFFICIENCY:** ▪ Number of network-level research projects **PERFORMANCE/VALUE:** ▪ Number of network-level research projects
Quality Assurance		
Collaborative	▪ Establish committee	**EFFICIENCY:** ▪ Number of committee meetings
Shared	▪ Established, written quality assurance (QA) plan (QA methodology stressing health outcomes, peer review, systematic data collection, etc.)	**EFFICIENCY:** ▪ Number of policies established for quality assurance measures
Integrated	▪ Standardized QA plan and activities network-wide ▪ Dedicated QA staff network-wide	**PERFORMANCE/VALUE:** ▪ Amount saved from network-wide QA activities

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OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Service Delivery	
Collaborative ▪ Establish dedicated nurse and social work case managers ▪ Train pre-authorization and case management staff on regulations and guidelines, benefits, and community resources ▪ Develop community resource manual for staff training and reference ▪ Develop programs that target preventive care	**EFFICIENCY:** ▪ Number of dedicated nurse and social work case managers ▪ Number of trainings on regulations, guidelines, benefits, and community resources
Shared ▪ Establish network of skilled nursing and ancillary services with timely admission/service guarantees ▪ Common assessment tool for comprehensive health and social status ▪ Develop procedures for identifying high risk members and assign case manager ▪ Develop system reports for managing hospital/SNF admissions and length of stay ▪ Develop programs to monitor/manage isolated, high risk members (telephone calls, visitations, community programs, etc.) ▪ Establish relationship with peer review organization and establish procedures for quarterly chart reviews of hospitalized members ▪ Shared medical advisory group	**EFFICIENCY:** ▪ Number of network skilled nursing and ancillary services ▪ Number of policies procedures for monitoring high-risk members
Integrated ▪ Single medical advisory group	**PERFORMANCE/VALUE** ▪ Standardized quality of services across network based on peer review ▪ Medical error rate

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PROGRAM OUTCOME MODEL FOR NETWORKS
Core Area: <u>FINANCE</u>

OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Grants Management	
Collaborative ▪ Review PINS and disseminate information ▪ Coordinate common strategy	**EFFICIENCY:** ▪ Number of common grants management policies and procedures ▪ Number/type of grants awarded requiring collaboration ▪ Number of grant compliance issues **PERFORMANCE/VALUE:** ▪ Amount/value of grants applied to centers for patient care
Shared ▪ Joint staff collects information and develops reports ▪ Technical assistance ▪ Implement grants management strategy	**EFFICIENCY:** ▪ Number of joint staff ▪ Number of grant compliance issues **PERFORMANCE/VALUE:** ▪ Amount saved from a shared grants management staff ▪ Amount/value of grants applied to centers for patient care
Integrated ▪ Centralized staff administers and monitors grants ▪ Centralized grants management department	**EFFICIENCY:** ▪ Number of grants managed at network-level ▪ Number/percent of collaborators using centralized grants management ▪ Number of grants compliance issue ▪ Number of grants awarded requiring integration **PERFORMANCE/VALUE:** ▪ Increase in patient outcomes from integrated grants ▪ Amount saved from core grants management staff ▪ Amount/value of grants applied to centers for patient care
Claims Processing and Billing	
Collaborative ▪ Common policies and shared staff training ▪ Train claims processing staff on regulations, guidelines for processing benefits, etc.	**EFFICIENCY:** ▪ Number of common policies ▪ Documented improvements in claims/bills submission ▪ Number of trainings for claims processing staff ▪ Number of shared staff training PERFORMANCE VALUE: ▪ Amount of savings from shared training ▪ Amount of increased revenue from improved claims processing

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OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Shared • Shared staff, some same but separate systems • Common policies in claims process and tracking • Load system with appropriate provider files, pricing system, and benefit structures • Load hospital discounts granted by States in service area into system • Develop system to track claims aging • Develop system for priority payment of appeals	**EFFICIENY:** • Number of shared claims processing staff • Number of average days to pay claim, • Number of claims processed and collected • Percent claim pain in X number of days • Increase/Reduction in denial rates • Number of programs loaded on hospital computer network or system • Number of systems developed for tracking claims and priority payment appeals • Number of shared staff positions **PERFORMANCE/VALUE:** • Amount of savings from shared staff • Improvements in collections per encounter • Patient satisfaction on claims process • Amount saved from a dedicated processing unit • Amount of savings from shared staff
Integrated • Single CFO and/or centralized management approach • Centralized network claims processing • Centralized billing staff and/or director of billing • Maintain records of all claims processed (paid and denied) for three years with easy access to claims records • Centralized network billing	**EFFICIENCY:** • Number/percent of collaborators involved in centralized claims processing • Increased specialization or proficiency of staff • Reduced numbers of denials • Percent of claims correctly adjusted at the time of service **PERFORM ANCE/VALUE:** • Number of increased collections as compared to pre-centralization • Number of reduced days in accounts receivable • Amount of savings from shared staff • Improvements in patient satisfaction surveys • A mount of consistent collections by month • Percent increase/decrease of self pay charges collected • Amount saved from centralizing claims processing • Increased staff satisfaction in claims processing department for accessible archived records

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OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Accounting: General Ledger, A/R, A/P, Payroll – System	
Collaborative - Training - Common policies - Develop policies on account reporting - Identify financial staff needs	**EFFICIENCY:** - Number of common policies - Number of trainings and participants - Number of days to produce financial statements - Number or type of audit adjustments - Number of financial staff positions filled
Shared - Shared staff, some same but separate systems - Common chart of accounts - Shared system support - Common analytical reports	**EFFICIENCY:** - Number of shared staff positions - Improved quality/timeliness of reporting **PERFORMANCE/VALUE:** - Amount of savings from shared staff
Integrated - Centralized chart of accounts - Unified system support - Single analytical reports - Single CFO and/or centralized management approach - Some central staff - Centralized server/systems	**ACCESS:** - Increased number or availability of grants due to greater fiscal accountability **EFFICIENCY:** - Number/percent of collaborators with centralized accounting system - Number of timely, accurate cost reports, FSRs, audits, and financials - Number of reports by location, department, funding source **PERFORMANCE/VALUE:** - Amount of savings from shared staff - Amount of savings from shared system and training - Number of audits without reportable conditions - Amount of improvement in asset ratios
Financial Policies and Procedures	
Collaborative - Network facilitates the development of model procedures for adoption by organizations - Collaborators approve 25 percent of common policies and procedures	**EFFICIENCY:** - Number of common policies and procedures developed
Shared - Use of shared staff /consultants to develop common policies.	**EFFICIENCY:** - Number of common policies and procedures developed - Number of policies approved by Collaborator Boards
Integrated - Board has approved 100 percent of common policies and procedure developed at the network level and accepted by members	**EFFICIENCY:** - Number of common policies and procedures - Number/percent of collaborators using common policies and procedures

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Network Outcome Indicators tool
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OUTPUTS Direct Products of Network Functions		EXAMPLES OF OUTCOME INDICATORS
External Audit		
Collaborative	• Different procedures and/or auditors • Discussion of data sharing	**PERFORMANCE/VALUE:** • Amount of shared data
Shared	• Common set of specifications • Some sharing of data	**PERFORMANCE/VALUE:** • Amount of shared data • Cost of using common specifications for all members
Integrated	• Sharing of common policies • One network auditor	**PERFORMANCE/VALUE:** • Amount of savings from using network auditor • Amount of shared data
Staff Education and Training		
Collaborative	• Individual training of common subjects in areas of financial systems, financial management, claims, and billing	**PERFORMANCE/VALUE** • Training plan improvement from shared curricula
Shared	• Some shared training by system "experts" • Joint training	**EFFICIENCY:** • Number of shared trainings **PERFORMANCE/VALUE:** • Amount of savings from having shared trainings • Performance on training post-tests
Integrated	• Implementation and monitoring of standard curriculum • Standard training curriculum	**EFFICIENCY:** • Number of standardized trainings **PERFORMANCE/VALUE:** • Amount of savings from using standardized trainings • Performance on training post-tests
Financial Management		
Collaborative	• Discussion on joint purchasing • Develop policy and procedures for financial staff	**PERFORMANCE/VALUE** • Number of areas identified for collaboration
Shared	• Joint purchasing for supplies, payroll expenses, audit fees, telecommunications • Shared financial staff • Joint negotiations on third party payments • Develop internal system to verify enrollment data • Establish enrollment processing procedures • Develop systematic reporting	**EFFICIENCY:** • Number of days to produce financial statements • Number of audit adjustments • Number of reportable conditions • Number of finance PCER recommendations • Number of policies and procedures on enrollment process • Number of policies and procedures on account reporting **PERFORMANCE/VALUE:** • Amount saved in personnel costs for centers • Amount saved from joint purchasing

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OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Integrated ▪ Centralized system for FSR, audits, UDS, etc. ▪ Centralized system to report financial ratios across member centers ▪ Centralized purchasing ▪ Centralized financial management of managed care activities	**EFFICIENCY:** ▪ Number of days to produce financial statements ▪ Number of audit adjustments ▪ Analyze enrollment data with payment information ▪ Reporting enrollment prior to the first of the month **PERFORMANCE/VALUE:** ▪ Number of reportable conditions and management comments ▪ Number and type of Finance PCER recommendations ▪ Amount saved in centralized training, system support, and purchasing ▪ Amount increased in third party payments

Registration/Cashier

Collaborative ▪ Develop policies and procedures for authorizations, s liding fee categories, establishing migrant/seasonal status ▪ Develop patient satisfaction survey	**EFFICIENCY:** ▪ Number of collaborations meeting to develop policies and procedures ▪ Percent change of patients enrolled in appropriate program based on eligibility
Shared ▪ Common policies in number or type of exceptions/error ▪ Joint patient satisfaction survey development and implementation	**PERFORMANCE/VALUE:** ▪ Increase/decrease in type of exceptions/errors ▪ Percent of collections to net charges ▪ Increase/decrease in patient satisfaction
Integrated ▪ Unified policies regarding exceptions/errors (authorizations, correct income, correct migrant/seasonal status)	**EFFICIENCY:** ▪ Increase/decrease in type of exceptions/errors **PERFORMANCE/VALUE:** ▪ Change in patient satisfaction surveys

Marketing/Product Development

Collaborative ▪ Joint review of marketplace and identification of opportunities for collaboration	▪ **EFFICIENCY** ▪ Number of joint opportunities identified
Shared ▪ Analysis/Assessment of managed care competition ▪ Conduct focus groups to validate data/proposed benefit structure and pricing ▪ Common benefit structure ▪ Common process in filing state insurance ▪ Joint marketing/sales and post-enrollment materials to reflect changes	**EFFICIENCY:** ▪ Number of focus groups conducted ▪ Number of common benefit structure ▪ Number of common process to filing state insurance ▪ Number of joint efforts in marketing/sales and post enrollment materials **PERFORMANCE/VALUE:** ▪ Amount saved from joint marketing/sales and post enrollment materials

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	OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Integrated	▪ Evaluate product options ▪ Conduct focus groups to validate data/proposed benefit structure and pricing ▪ Centralized benefit structure ▪ State insurance filings centralized	**EFFICIENCY:** ▪ Number of focus groups ▪ Time saved from centralized insurance filings **PERFORMANCE/VALUE:** ▪ Amount saved from centralized benefit structure
Utilization Management/Utilization Review (UM/UR)		
Collaborative	▪ Shared planning around UM/UR	**PERFORMANCE/VALUE:** ▪ Number/percent of collaborators participating in UM/UR planning
Shared	▪ Conduct individually under common protocols	**EFFICIENCY:** ▪ Number of common protocols **PERFORMANCE/VALUE:** ▪ Amount of savings due to common protocols
Integrated	▪ Centralized UM/UR ▪ Standardized or ▪ Centralized system	**PERFORMANCE/VALUE:** ▪ Number/percent of collaborators participating in standardized UM/UR
Capitation		
Collaborative	▪ Identify capitation activity among collaborators and in the marketplace	**PERFORMANCE/VALUE** ▪ List of capitation activity in the marketplace and among collaborators
Shared	▪ Conduct trial settlement of risk pools in advance of annual settlement to ensure accuracy ▪ Verify enrollment and capitation payments by provider monthly	**EFFICIENCY:** ▪ Number of enrollment and capitation payments verified by the provider **PERFORMANCE/VALUE:** ▪ High correlation with trial settlement risk pools and annual settlement
Integrated	▪ Unified capitation rates for primary care physicians and other providers ▪ Centralized provider data base system ▪ Centralized risk pools ▪ Annual settlement of pools	**PERFORMANCE/VALUE:** ▪ Amount saved from a unified capitation rate for primary care physicians and other providers ▪ Amount of staff time saved from a centralized provider database

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PROGRAM OUTCOME MODEL FOR NETWORKS
Core Area: <u>INFORMATION SYSTEMS</u>

OUTPUTS Direct Products of Network Functions		EXAMPLES OF OUTCOME INDICATORS
Management of IS		
Collaborative	▪ Formation of IS committee	**PERFORMANCE/VALUE:** ▪ Number of meetings ▪ Number of collaborative strategies ▪ Reduction in time/costs related to problem solving
Shared	▪ Shared staff	**PERFORMANCE/VALUE:** ▪ Number of meetings ▪ Number of shared strategies ▪ Reduction in time/costs related to problem solving
Integrated	▪ Single CIO and/or centralized management approach ▪ CIO	**PERFORMANCE/VALUE:** ▪ Number of meetings ▪ Number of integrated strategies ▪ Reduction in time/costs related to problem solving
Data		
Collaborative	▪ Common data elements ▪ Data converted into useful information	**EFFICIENCY:** ▪ Number of common data elements **PERFORMANCE/VALUE:** ▪ Amount of data collected
Shared	▪ Data compiled for common management reporting (data warehousing) ▪ Roll-up reporting ▪ Common data management	**PERFORMANCE/VALUE:** ▪ Amount of data collected ▪ Level of accuracy of data
Integrated	▪ Centralized database ▪ Standardized data elements ▪ Centralized database or data warehouse	**EFFICIENCY:** ▪ Number of standardized data elements ▪ Number/percent of collaborators using a centralized database **PERFORMANCE/VALUE:** ▪ Amount of data collected ▪ Number of network benchmarks ▪ Accuracy of data
Communication		
Collaborative	▪ Email capacity at collaborator level ▪	**PERFORMANCE/VALUE:** ▪ Number of staff with email

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OUTPUTS Direct Products of Network Functions		EXAMPLES OF OUTCOME INDICATORS
Shared	▪ Internet email capacity for all appropriate people	**PERFORMANCE/VALUE:** ▪ Number of staff with email
Integrated	▪ Email, intranet, web pages with common links ▪ Email, intranet, and web pages at the network level	**EFFICIENCY:** ▪ Number/percent of collaborators using common communication **PERFORMANCE/VALUE:** ▪ Number of staff with email ▪ Number of linked web pages
Staff Education and Training		
Collaborative	▪ Individual training of common subjects ▪ Training of all levels of staff within network collaborators	▪ **EFFICIENCY** ▪ Number of joint trainings held
Shared	▪ Some shared training by system "experts" ▪ Shared training	**EFFICIENCY:** ▪ Number of shared trainings **PERFORMANCE//VALUE:** ▪ Amount of savings from having shared trainings
Integrated	▪ Training program at network level ▪ Standard training curriculum	**EFFICIENCY:** ▪ Number of standardized trainings ▪ Number/percent of collaborators using standardized trainings **PERFORMANCE/VALUE:** ▪ Amount of savings from using network trainings ▪ Number of programs provided through full-time training department
Reporting		
Collaborative	▪ Common reports	**PERFORMANCE/VALUE:** ▪ Number of common reports ▪ Number of common data elements
Shared	▪ Roll-up reporting	**PERFORMANCE/VALUE:** ▪ Number of common reports/benchmarking reports ▪ Number of common data elements
Integrated	▪ Reports produced at network level ▪ Network-level reports	**EFFICIENCY:** ▪ Amount of timely notification of issues facing CHCs ▪ Number/percent of collaborators using common reports **PERFORMANCE/VALUE:** ▪ Number of timely, analytical reports
Infrastructure		
Collaborative	▪ Individual assessments at the collaborator level ▪ Strategic planning ▪ Development of joint RFP	**EFFICIENCY:** ▪ Number of joint RFPs

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	OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Shared	▪ Group purchase of systems ▪ Interfaced systems ▪ Group purchasing	**EFFICIENCY:** ▪ Number of items purchased centrally **PERFORMANCE/VALUE:** ▪ Amount of savings from shared purchases of hardware and software
Integrated	▪ Central server or data warehouse	**EFFICIENCY:** ▪ Time saved of one-time system upgrades ▪ Amount of down time ▪ Number/percent of collaborators using central data warehouse **PERFORMANCE/VALUE:** ▪ Number/percent of collaborators using central data warehouse ▪ Increase in the level, type, or use of applications

Support

Collaborative	▪ Common support agreem ent ▪ Support agreements	**PERFORMANCE/VALUE:** ▪ Amount of savings from using common support agreement
Shared	▪ Sharing staff	**EFFICIENCY:** ▪ Number of shared staff **PERFORMANCE/VALUE:** ▪ Amount of savings from shared staff
Integrated	▪ Central help desk/support performed at network level	**EFFICIENCY:** ▪ Number/percent of collaborators using central help desk **PERFORMANCE/VALUE:** ▪ Number of responses to help desk inquiries ▪ Amount of savings from using central help desk

Policies and Procedures

Collaborative	▪ Development of joint policies and procedures ▪ Joint policies and procedures	**EFFICIENCY:** ▪ Number of joint policies and procedures
Shared	▪ Each center using common policies and procedures ▪ Common policies and procedures	**EFFICIENCY:** ▪ Number of common policies and procedures ▪ Number/percent of collaborators using common policies and procedures

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	OUTPUTS Direct Products of Network Functions	EXAMPLES OF OUTCOME INDICATORS
Integrated	▪ Standardized policies and procedures	**PERFORMANCE/VALUE** ▪ Accurate/comparable data from all collaborators available for planning purposes

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APPENDIX A

EVALUATION OF PROGRESS

According to <u>Morbidity and Mortality Weekly Report</u> "Framework for Program Evaluation in Public Health," evaluation should be considered a routine operation when the emphasis is on practical, ongoing evaluation that involves operations staff and non-evaluation experts[2].

Evaluation of a program or, in this case, a network, is essential in demonstrating the effectiveness of network activities through quantitative and qualitative measures. The goal of evaluation is to illustrate efficiencies, strengths, challenges, and increased performance in target areas through network functions. Through evaluation, a network may make lasting impacts, such as basing decisions on systematic judgments instead of assumptions.

The following sections on evaluation and evaluation design are adapted from the "Framework for Program Evaluation in Public Health." Although there are many tools available, the Center for Disease and Control (CDC) captures the essence of the art and science of evaluation.

Network evaluation results in some of the following:
- Demonstrating progress or change (i.e. strengths and challenges of network activities)
- Improving data collection methods
- Reporting supportable findings to the network members, the community, and funding sources.
- Measuring network objectives and goals
- Using data to support on-going strategic planning
- Measuring network activities for:
  - Increased access
  - Enhanced efficiency
  - Higher performance and value

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FRAMEWORK FOR NETWORK EVAULATION
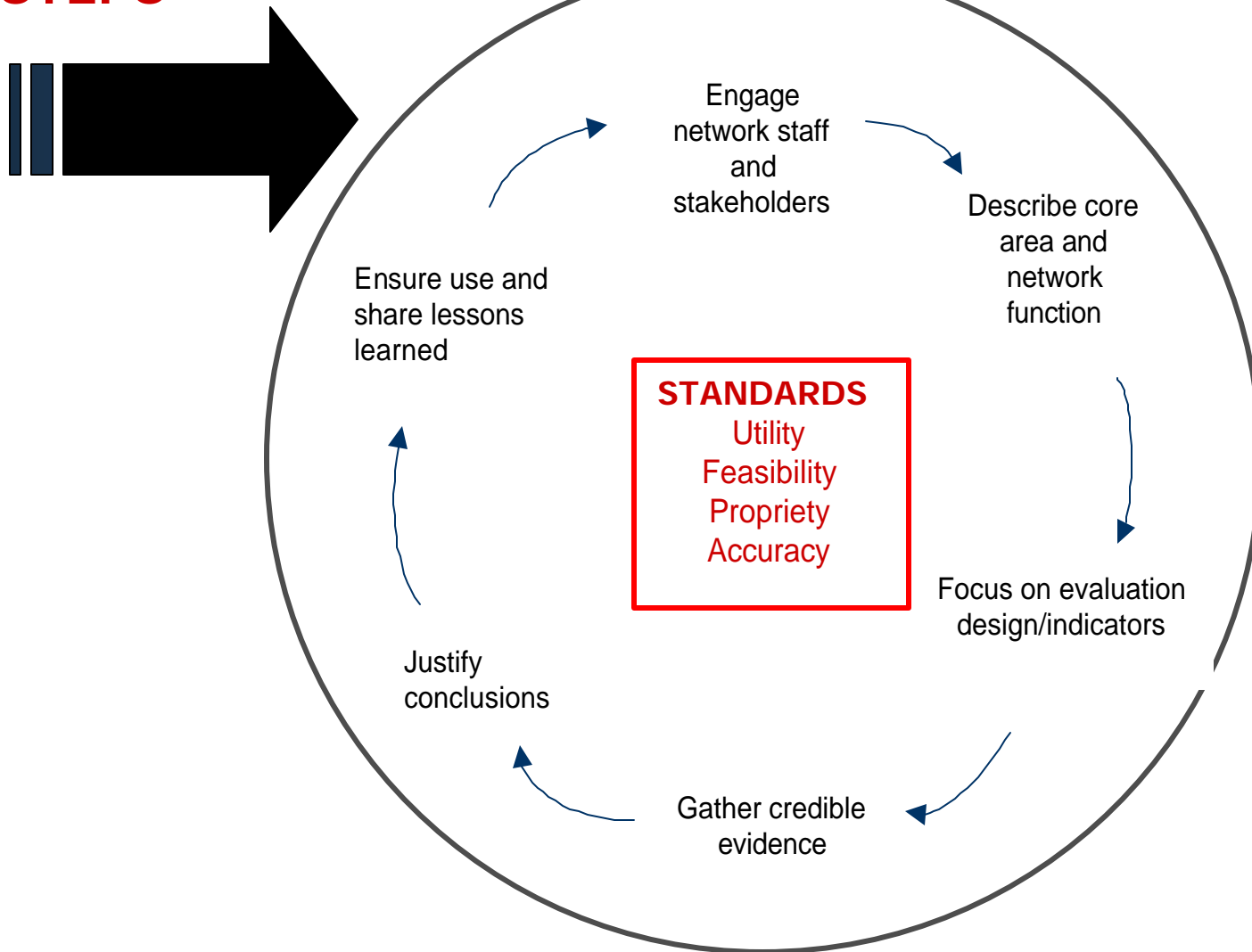
Steps For Network Evaluation

The steps for network evaluation described here may not be linear; however, they provide a foundation for the next step.

- **Engage network staff and stakeholders:** Identify stakeholders that are impacted by network activities and entities that will use evaluation data (i.e. network members, clients, staff, funding entities, CHC Board, etc.) Engage stakeholders to set goals and identify purpose of the evaluation.

- **Describe core area and network function:** Discuss the core area and network function to be evaluated to set a frame of reference in the development of the evaluation.

- **Focus on evaluation design/indicators:** The iterative process of identifying and defining the evaluation purpose will guide how the evaluation will be conducted. Exhibit 1 provides examples of possible network functions in a core area that may be used to measure efficiency, access, and/or performance.

- **Gather credible evidence:** Collect baseline information that is relevant and believable in answering the purpose of the evaluation. Collect baseline data (i.e. center UDS data, local health indicators, information prior to network activities, etc.) to identify possible changes after evaluation.

- **Justify conclusions:** Conclusions are justified when agreed-upon values are linked to the evidence collected. Analysis and synthesis, interpretation, judgments, and recommendations develop from evaluation data.

- **Ensure use and share lessons learned:** Develop an improvement action plan (by Board and staff) based on the results of the evaluation. In addition, disseminate information to CHC Board/Staff, network staff, community, and clients.

Please refer to Figure 2, Framework for Network Evaluation to see the circle of evaluation and improvement.

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Figure 2. Framework for Network Evaluation

STEPS

Engage network staff and stakeholders

Describe core area and network function

Ensure use and share lessons learned

STANDARDS
Utility
Feasibility
Propriety
Accuracy

Focus on evaluation design/indicators

Justify conclusions

Gather credible evidence

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Standards for Network Evaluation

The Joint Commission on Standards for Educational Evaluation developed standards for evaluation based on ethical principles. The standards are main points to consider when developing any evaluation[4].

- **Utility:** Ensure the evaluation will serve the information needs of those that are impacted by the evaluation (i.e. network members, network staff, community, clients, etc.)

- **Feasibility:** Ensure the evaluation is viable, non-disruptive, and economical.

- **Propriety:** Ensure that ethical standards and legal compliance are ensured, and the welfare of those involved in the evaluation is protected. Any conflicts of interest should be resolved in an open and fair manner.

- **Accuracy:** Ensure the evaluation will reveal and convey only technically accurate information about features that determine worth or merit of the function being evaluated.

Before beginning this process, there are several questions that the network board should consider.

Before designing an evaluation:
- What is the best way to evaluate?
- What do we want to learn from the evaluation?
- How will we use the learning to make network activities more effective?

Designing an evaluation:
- What will be evaluated? (i.e. inputs, functions, outputs, outcomes)
- What aspects of the network will be considered when judging network performance (i.e. level of integration, network communication, participation of stakeholders, etc.)?
- What standards (i.e. level of performance) must be reached for the network to be considered successful? (i.e. use of targets, goals, objective, etc.]
- What evidence will be used to indicate how the network has performed (i.e. quantitative measures, qualitative measures, comparison to baseline data, etc.)?
- How will the lessons learned from the inquiry be used to improve network effectiveness and efficiency?

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References

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2. Joint Commission on Standard for Educational Evaluation, "Program evaluation standards: how to assess evaluations of educational programs", 2nd ed. Thousand Oaks, CA: Sage Publications, 1994

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